

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 — 0 2 0

2. STATE:

MN

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1916(g) of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY '02 \$ (624,000)

b. FFY '03 \$ (1,011,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

12o of Attachment 2.6-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

Premium formula for TWWIIA Basic Coverage Group

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mary B. Kennedy

14. TITLE:

Medicaid Director

15. DATE SUBMITTED:

September 12, 2001

16. RETURN TO:

Stephanie Schwartz
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3853

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

9-17-01

18. DATE APPROVED:

10/11/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

December 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

Cheryl Harris

21. TYPED NAME:

Cheryl A. Harris

22. TITLE:

Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
SEP 17 2001
DMCH - MI/MN/WI

Revision:

ATTACHMENT 2.6-A

Page 12o

OMB No.:

State/Territory: Minnesota

| Citation | Condition or Requirement |
|--|---|
| Sections 1902(a)(10)(A)(ii)(XV) and 1916(g) of the Act (cont.) | <p><u>Premiums and Other Cost-Sharing Charges</u></p> <p>For the Basic Coverage Group the agency's premium or other cost-sharing charges, and how they are applied, are described below.</p> <p>Payment of a premium applies to an individual who has gross income <u>at or greater than 200 100 percent</u> of the federal poverty level by family size. The premium amount is <u>10 percent of the amount of gross income that is above 200 percent of poverty by family size based on a person's gross earned and unearned income, the applicable family size and a sliding fee scale that begins at one percent of income at 100 percent of the Federal poverty guidelines and increases to 7.5 percent up to income of 300 percent of the Federal poverty guidelines, and remains at 7.5 percent for income above 300 percent of the Federal poverty guidelines.</u></p> <p><u>Annual adjustments based upon changes in the federal poverty guidelines are effective July 1 of each year.</u> No other cost-sharing charges apply.</p> |

TN No. 01-20

Supersedes

TN No. 00-26

Approval Date: _____

Effective Date: 12/1/01

HCFA ID: